Title:
False or Misleading Information Offence
IA No: 6106

Lead department or agency:
Department of Health

Other departments or agencies:

Impact Assessment (IA)

Date: 04/11/2013

Stage: Final

Source of intervention: Domestic

Type of measure: Primary legislation

Contact for enquiries: Jeremy Nolan

Summary: Intervention and Options

RPC Opinion: RPC Opinion Status

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANCB on 2009 prices)	**In scope of One-In, One-Out?**	**Measure qualifies as**
-£1.76m	N/A	N/A	No	NA

What is the problem under consideration? Why is government intervention necessary?

Health and social care providers often have access to more information on their service provision and quality of care than other parties in the system. The public, commissioners and regulators rely on providers of NHS care to share this information and ensure that it is accurate. There are incentives for providers to supply false or misleading information if otherwise it indicates their service quality is poor; e.g. to preserve its reputation and avoid consequences from regulators, commissioners and service users. Misleading information can undermine commissioning and regulation and can prevent issues being identified, lessons being learnt and corrective action been taken. This can enable poor care to manifest and spread.

What are the policy objectives and the intended effects?

The policy objective is to deter providers from deliberately supplying false or misleading information to the public, regulators and commissioners, and to hold those who do to account. The intended effects are to improve transparency and confidence in the supply and publication of such information, allowing identification of service issues and corrective interventions to be taken earlier. The result of which could prevent future incidents of poor care, and improve the quality of care in general, through better provider internal control, better patient choice, and better commissioning and regulation. It would also mean providers could be held fully accountable for misleading the public, regulators and commissioners.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Option 1: False or Misleading Information Criminal Sanction: Introduce a criminal offence for health and social care providers that supply or publish false or misleading information (and for directors and other senior individuals who consent or connive in, or are negligent in relation to, an offence by the provider), targeted through subsequent regulations on certain types of information supplied by providers of NHS secondary care, such as the data required to compile mortality rates.

Option 2: Do nothing. Providers would still be expected to comply with legal obligations to supply information by supplying accurate information. However, existing offences, and the consequences and mechanisms of accountability, would continue to be insufficient in nature and scope and/or provide an insufficient deterrent against supplying or publishing false or misleading information.

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** Month/Year

Does implementation go beyond minimum EU requirements?			N/A			
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** Yes	**< 20** Yes	**Small** Yes	**Medium** Yes	**Large** Yes	
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** N/A	**Non-traded:** N/A		

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.

Signed by the responsible Minister: _____ Date: Norman Lamb MP 28 December 2013

Summary: Analysis & Evidence

Policy Option 1

Description: False or Misleading Information Offence

FULL ECONOMIC ASSESSMENT

Price Base Year 2011	PV Base Year 2013	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: £0.00	**High:** -£8.06m	**Best Estimate:** -£1.76m

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	N/A	N/A	£0.00	**£0.00**
High	N/A		£1.0	**£8.0m**
Best Estimate	N/A		£0.2	**£1.8m**

Description and scale of key monetised costs by 'main affected groups'

There will be costs to the CPS and HMCTS of prosecutions brought under this offence. It is expected that the scope of the offence will be limited to around 500 providers and less than 5% of these will commit the offence. Providers that are prosecuted will face the legal costs of mounting a defence. If directors or other senior individuals are found to have consented or connived in, or are negligent in relation to, an offence by the provider they may also face prosecution.

Other key non-monetised costs by 'main affected groups'

Some providers may change their behaviour in response to this new offence and may spend more time and resource on complying with information requests; these are necessary costs that should already have been incurred. Further there may be some distraction costs for providers involved in legal action. Other organisations may need to assist the Police and Crown Prosecution Service with investigations and prosecutions; this will have resource implications.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	N/A	N/A	Unquantified	**Unquantified**
High	N/A		Unquantified	**Unquantified**
Best Estimate	N/A		Unquantified	**Unquantified**

Description and scale of key monetised benefits by 'main affected groups'

It has not been possible to monetise any benefits.

Other key non-monetised benefits by 'main affected groups'

The information available to the public, service users, commissioners and regulators should be of a higher quality, as providers who would have been complying with information requests with false or misleading information are deterred from doing do. This makes health care provision more transparent. In addition, it will allow providers of NHS care to be held to account if they have misled the public and the system.

Key assumptions/sensitivities/risks **Discount rate (%)** 3.5

It is not possible to know how provider behaviour will change in response to the new offence. They could take: a "bare minimum" approach, more time than necessary, and/or include numerous caveats that hinder interpretation. This could adversely affect, rather than improve, transparency. It is not possible to know how many providers would be investigated and prosecuted under the proposed offence nor the resources required per prosecution; any estimates are based on assumptions.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: N/A	**Benefits:** N/A	**Net:** N/A	No	NA

Evidence Base

Policy Background

1. Providers of health services and social care are required to share management and performance information with regulators, commissioners and the public. This data and information forms a vital basis of commissioning decisions, regulatory assessments of quality and safety, and providers' own monitoring and controls.
2. Providers of health services and social care may supply information routinely through central data collection systems (for example, the mandatory Commissioning Data Sets supplied in order for Hospital Episode Statistics to be compiled by the Health and Social Care Information Centre), or directly to the requesting body such as regulators or commissioners. Providers are required to provide accurate and truthful information.
3. The Public Inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of the Mid-Staffordshire NHS Foundation Trust from January 2005 to March 2009 concluded recently. The final report highlighted issues of inaccurate information and the role of this in the lack of action to investigate issues with care, both within the Trust and from other bodies.

The evidence base of this impact assessment is structured as follows:

Section A: Definition of the underlying problem and rationale for government intervention

Section B: Policy objectives and intended effects

Section C: Description of the options

Section D: Costs and benefits assessment of the options (including specific impacts)

Section E: Summary of specific impact tests

Section F: Summary and conclusion

A: Definition of the underlying problem and rationale for government intervention

4. Health and social care providers often have access to more information on their service provision and quality of care than other parties in the system. To address this, providers of NHS care are required to share this information and comply with requests from regulators and commissioners. However, there are incentives to provide false or misleading information if otherwise it indicates the provider's service quality is poor.
5. Where a provider is identified as providing poor care it may face a range of consequences from reputation damage to regulatory enforcement action. Provision of poor care may mean service users and commissioners may choose to use alternative providers which would impact on its income streams. In addition, poor care may see a provider subject to enforcement action by the regulators which may range from a warning, to service or provider closure, to a fine and/or prosecution. These consequences provide incentives for providers to distort or omit information that indicates potential service issues.
6. Data and information forms a vital basis of commissioning decisions, regulatory assessments on quality of safety and providers' own monitoring and controls. False or misleading information can enable poor and dangerous care to manifest and prevent regulatory or other corrective interventions to address the poor care. It can also prevent lessons being learnt and disseminated across the system.
7. There is evidence that providers may minimise, omit, or cover up information and data which highlights issues with services, and/or may not exercise due diligence, and this can adversely

impact care. For example, the Francis Inquiry found that the Mid-Staffordshire NHS Foundation Trust made inaccurate statements about its mortality rates[1], although Francis does not state that the Trust did this deliberately. The inaccurate statements about mortality rates delayed any investigation and thus identification of service issues. As a result corrective action was delayed and poor quality care was allowed to continue unchecked. It is estimated that many more people than expected died at Mid Staffordshire Hospital. There were a number of factors involved but provision of inaccurate information by the Trust was a key component in enabling this to occur.

8. Providers are already required and expected to provide accurate information when complying with a statutory obligation. The Health and Social Care Information Centre (HSCIC) already has the power under the Health and Social Care Act 2012 to publish its assessment of the quality of information it collects from providers against agreed information standards. However, this is an assessment of the quality of information only (e.g. its completeness) and does not identify or investigate whether the information may have been falsified. If information collected by the HSCIC appears to be unusual or inaccurate, it is normally returned to the provider to be corrected and resubmitted. There is currently no direct penalty for providing false or misleading information to HSCIC.

9. There are existing offences that deal with the supply or publication of false or misleading information, or more specifically false statements and false representations, such as section 2 of the Fraud Act 2006, section 19 of the Theft Act 1968 and section 5 of the Perjury Act 1911, but none of these sufficiently satisfy the policy intentions of the proposed new offence for the following reasons:

    - These Fraud Act and Theft Act offences address a specific type of behaviour (i.e. making a gain or loss, and deceiving members or creditors, respectively), which will not arise in all instances of this policy problem.
    - All three offences are fault-based (rather than strict liability offences).
    - These Fraud Act and Perjury Act offences are applicable to both corporate bodies and individuals, whereas the Theft Act offence is applicable to individual officers only.

10. In relation to provider organisations that are corporate bodies or unincorporated associations (such as GP partnerships), the proposed new offence is a strict liability offence; the prosecution will not need to prove that there was intent to provide false or misleading information, by a "directing mind", as would be typically required to prove a fault-based offence against a corporate body. However, where the strict liability offence is committed by the provider, a fault-based offence may also arise in relation to individual directors or other senior individuals who consent or connive in, or are negligent in relation to, an offence by the provider. Therefore, a fault-based offence is applicable to individuals where a strict liability offence is also committed by the provider organisation. By contrast, offences under the Fraud Act, Theft Act and Perjury Act provisions referred to above may be committed by individuals independently of any offence by a corporate body or unincorporated association.

11. The Health and Social Care Act 2012 makes provision to extend aspects of the Competition Act 1998 and the Enterprise Act 2002. As a result, there is already statutory provision for a criminal offence of providing false or misleading information to Monitor, but only in relation to certain (e.g. Monitor's "competition functions"), but not all, of Monitor's functions. These provisions do not extend to other statutory obligations to provide information to other regulators, commissioners, the Secretary of State or HSCIC.

12. In summary, existing offences, and the consequences and mechanisms of accountability, are an insufficient deterrent and/or insufficient in nature and scope to address the provider incentive to provide misleading or false information, which may benefit the provider at the expense of poor quality of care.

13. In addition, the Inquiry into Mid Staffordshire NHS Foundation Trust recommended that there should be a statutory duty on directors of healthcare organisations to be truthful in any information given to a health care regulator or commissioner, either personally or on behalf of the organisation, where given in compliance with a statutory obligation.[2] Extending the scope of the false or

[1] 2013, Francis R, Mid-Staffordshire Foundation Trust Public Inquiry, Chapter 22, Para 22.4-22.23

[2] 2013, Francis R, Mid-Staffordshire Foundation Trust Public Inquiry, Recommendation 182

misleading offence to cover directors or other senior individuals who consent or connive in, or are negligent in relation to, an offence by the provider will ensure that the proposed offence is in line with the handling of offences committed under other regulatory systems – such as Health and Safety At Work offences and offences under CQC legislation – where directors and other senior individuals can also be held liable for offences by a corporate body. This will ensure that the senior individuals in charge of the provider organisation personally face sufficiently strong incentives to provide accurate information (as the proposed sanctions for the corporate body would not necessarily directly affect those individuals making the decisions), and can be held to account for their failings.

Section B: Policy objectives and intended effects

14. As described above, despite current requirements to provide accurate information, providers still face incentives to provide false or misleading information. Therefore a stronger deterrent and mechanism to hold non-compliant providers to account is required. In line with the Francis recommendations, and to ensure that the individuals in charge within the organisation also face a sufficiently strong deterrent and can be held to account for any failings, the offence will also cover directors and other senior individuals within the organisation who consent or connive (or are negligent in relation to) an offence by the provider.

15. The policy objective is to deter providers from supplying false or misleading information to the public, regulators and commissioners and to hold those that do so to account.

16. The intended effects are to improve transparency and identification of issues which allows corrective action to be taken as soon as possible. This could help prevent future incidents and improve quality of care through better provider internal control, better patient choice, and better commissioning and regulation. It would also mean providers could be held fully accountable for misleading the public, regulators and commissioners.

Section C: Description of the options

Option 1: False or misleading Information Criminal Sanction: Introduce a criminal offence for health and social care providers that supply false or misleading information (and for directors and other senior individuals who consent or connive in, or are negligent in relation to, an offence by the provider), targeted through subsequent regulations on certain types of information supplied by providers of NHS secondary care, such as the data required to compile mortality rates.

17. This offence does not create any additional data or information requests. The offence will apply to existing legal obligations to supply information, and any future legal obligations. Providers of NHS secondary care would still be required to provide accurate information in compliance with statutory information requests as they are now. However, under this option the corporate body would face criminal prosecution if it provides false or misleading management and performance information, whilst directors and other senior individuals within the organisation might also face prosecution if it is found that they consented or connived in, (or were negligent in relation to) an offence by the provider.

18. Providers that make a genuine administrative error would not be prosecuted if they can evidence a defence that due diligence had been undertaken to avoid providing false or misleading information. Subject to the usual two-stage test before commencing a prosecution (that there is a sufficiency of evidence and that prosecution is in the public interest), providers that intentionally or recklessly provided false or misleading information could face prosecution.

19. Providers that are prosecuted could be subject to a remedial order, publicity order and/or an unlimited fine. A remedial order will permit the Court to specify steps that must be taken by the provider to remedy the breach that led to the conviction. A publicity order could require the convicted organisation to publicise that it has been convicted, specifying particulars of the offence, the amount of any fine imposed and the terms of any remedial order made. Breach of either a remedial order or a publicity order would result in a further offence and a further fine. Directors or

other senior individuals who consent or connive in (or are negligent in relation to) an offence by the provider could be subject on conviction to unlimited fines or custodial sentences of up to two years or both.

20. These penalties are assumed to be sufficient deterrents to bring about changes in behaviour. It is assumed that this will incentivise the board of directors of a provider, which is responsible for the corporate body and ultimately signs off information returns, to ensure there is an culture of openness and honesty in the supply or publication of information and there is sufficient due diligence in place. Although a stronger deterrent effect could be created by extending the offence to cover all staff within an organisation, this is not desirable as it is likely to cause significant anxiety and disruption amongst junior staff, and is likely to lead to considerable unintended consequences. For example, if all junior staff could be held personally responsible for any data they produce, this is likely to lead to substantial unnecessary double checking and re-checking of data that would place a disproportionate cost burden on providers. The policy intention is to incentivise and hold to account those individuals with real authority and responsibility within the organisation, to encourage a more open and transparent culture to be adopted with sufficient due diligence processes in place to ensure information is accurate. Extending liability to all junior staff is likely to be counterproductive to this aim.

21. It is assumed that cases will be tried through either Magistrates' Courts or the Crown Court. For prudence, in terms of costing, this impact assessment assumes all cases would be tried through the more costly Crown Court.

22. In relation to provider organisations, the criminal offence will be a strict liability offence of providing false or misleading information with a due diligence defence. The mechanism for identifying a body that has committed this offence is likely to be through individual action highlighting an issue or issues being picked up in existing data validation processes already used in the system. Potentially there could be increased monitoring or checks although this is expected to be minimal. Therefore identification of potential non-compliance is not expected to require significant additional resources. However, any potential non compliance identified may require significant investigation before a decision to prosecute is reached. It is intended that this investigation would be carried out by the police, with support and advice from other organisations as necessary. Some providers may initially be investigated but then not prosecuted if due diligence is demonstrated. The policy objective is to target only those providers that are suspected of purposefully (rather than accidentally) providing false or misleading information. Prosecutions would only be pursued where it is in the public interest to do so. The current mechanism of returning data to the provider for correction and resubmission will continue to be used to deal with administrative errors.

23. It is not possible to know how many providers would be subject to investigation and prosecutions under this new offence. However, the total number of providers that could possibly be in scope of this new offence is expected to be around 500[3]. This provides a maximum upper bound of potential investigations and prosecutions. It is expected that the vast majority of providers undertake due diligence and do not purposefully provide false or misleading information, and therefore would not be subject to investigation and prosecution. This offence is required as it is expected that some providers will be purposefully or recklessly providing inaccurate information. Although this is expected to be a small minority, the implications of even one provider doing it are severe enough to warrant a new offence to bring about prosecutions.

24. Given all of the above, it is expected that there would be fewer than 10 investigations and potential prosecutions of providers each year. A reasonable range is expected to be around 0 and 25 (5% of providers potentially in scope).

25. In terms of directors and other senior individuals within provider organisations, the proposed offence only provides for the prosecution of an individual where the corporate body is also found to be guilty of an offence. Thus only a subset of the number of investigations and potential prosecutions identified above might also involve the prosecution of an individual. Evidence from other offences that include a consent, connivance or neglect clause for directors and other senior individuals suggest that the number of additional prosecutions for individuals is likely to be low. Comparing the annual total number of prosecutions brought about by the Health and Safety Executive between 2007/08 and 2010/11 against the number of directors prosecuted under Section

[3] Based on the number of providers who submit information to Hospital Episode Statistics. Providers of HES data are providers of care provided in England by NHS hospitals and for NHS hospital patients treated elsewhere.

37 of the Health and Safety at Work Act 1974 in each year (which makes the provision for prosecution of directors and other senior individuals for consent, connivance or neglect), suggests that individual prosecutions consisted of between 2% and 8% of all prosecutions brought. Applying the maximum figure of 8% to the maximum estimate of 25 provider cases, this suggests that only 2 cases would also involve prosecuting directors or other senior individuals in the organisation. Building on the best estimate of 10 provider cases per year, this suggests that at most there could be 1 provider case also involving the prosecution of a director or other senior individuals a year.

26. Following a prosecution, it will be possible for providers and individuals to appeal. It is expected that only the cases where there is unlikely to be a due diligence defence would be tried at all. Therefore it is not expected that there will be a significant number of appeal cases.

27. It will be ensured that there is clarity and not duplication between this provision and existing provisions in relation to data supplied to Monitor.

Option 2: Do nothing

28. Under this option providers would still be required to comply with statutory information requests by providing accurate information. The Health and Social Care Information Centre (HSCIC) already has the power under the Health and Social Care Act 2012 to publish its assessment of the quality of information it collects from providers against agreed information standards. However, this is an assessment of the quality of information only (e.g. its completeness) and does not identify or investigate whether the information may have been falsified. If information collected by the HSCIC appears to be unusual or inaccurate, it is normally returned to the provider to be corrected and resubmitted.

29. There are existing offences that deal with the supply or publication of false or misleading information, or more specifically false statements and false representations, such as section 2 of the Fraud Act 2006, section 19 of the Theft Act 1968 and section 5 of the Perjury Act 1911, but none of these sufficiently satisfy the policy intentions of the proposed new offence for the following reasons:

    - These Fraud Act and Theft Act offences address a specific type of behaviour (i.e. making a gain or loss, and deceiving members or creditors, respectively), which will not arise in all instances of this policy problem.
    - All three offences are fault-based (rather than strict liability offences).
    - These Fraud Act and Perjury Act offences are applicable to both corporate bodies and individuals, whereas the Theft Act offence is applicable to individual officers only.

30. In relation to provider organisations that are corporate bodies or unincorporated associations (such as GP partnerships), the proposed new offence is a strict liability offence; the prosecution will not need to prove that there was intent to provide false or misleading information, by a “directing mind”, as would be typically required to prove a fault-based offence against a corporate body. However, where the strict liability offence is committed by the provider, a fault-based offence may also arise in relation to individual directors or other senior individuals who consent or connive in, or are negligent in relation to, an offence by the provider. Therefore, a fault-based offence is applicable to individuals where a strict liability offence is also committed by the provider organisation. By contrast, offences under the Fraud Act, Theft Act and Perjury Act provisions referred to above may be committed by individuals independently of any offence by a corporate body or unincorporated association.

31. The Health and Social Care Act 2012 makes provision to extend aspects of the Competition Act 1998 and the Enterprise Act 2002. As a result, there is already statutory provision for a criminal offence of providing false or misleading information to Monitor, but only in relation to certain (e.g. Monitor’s “competition functions”), but not all, of Monitor’s functions. These provisions do not extend to other statutory obligations to provide information to other regulators, commissioners, the Secretary of State or HSCIC.

32. In summary, existing offences, and the consequences and mechanisms of accountability, are an insufficient deterrent and/or insufficient in nature and scope to address the provider incentives outlined above. The identified incentives to provide false or misleading information if it highlighted potential service issues would remain.

Section D: Costs and benefits assessment of the options (including specific impacts)

33. As per standard practice, the marginal impacts of this Option 1, compared to the baseline of do-nothing (Option 2), are considered below.

Costs

Investigating and prosecuting bodies

34. The police are likely to be responsible for charging providers. They will require assistance from another body, probably in the health and social care system to investigate potential breaches of the law and build a case. This information would then be passed to the Crown Prosecution Service (CPS) for it to assess and commence prosecution proceedings, if it is in the public interest to do so.

35. The mechanism for identifying a provider that has committed this offence is likely to be through individual action highlighting an issue or issues being picked up in existing data validation processes already used in the system. Potentially there could be increased monitoring or checks by the responsible organisation, however this is expected to be minimal. Therefore identification of potential non-compliance is not expected to require significant additional resources. However, any potential non compliance may require significant investigation. Therefore there may be costs to the police of investigation, helping build the case and evaluating the evidence, to assist the CPS making a decision on whether and who to prosecute. Other organisations may also be involved in this process to provide support and additional advice to the police and the CPS. As such, it is not possible to know how much police or other time would be required at this stage and so it is not possible to quantify these potential costs.

36. Following investigation, some providers, directors and other senior individuals may be prosecuted. As this is a new offence it is not possible to know how much time or resource a CPS prosecution would require. As a proxy, Ministry of Justice data suggests the average costs to the CPS per defendant in the Crown Court are £2560 (2011/12 prices). These are average costs based on a varied sample of offences and trials.

37. Based on the assumption that there will be fewer than 10 provider cases a year with a range of 0-25 the costs to the CPS may be between £0 and £64,000 with best estimate of around £26,000 per annum.

38. In terms of prosecution of directors and other senior individuals, we expect that in most circumstances there would only be one individual who would be prosecuted i.e. the director who has responsibility for information provision. At a maximum, the whole executive board could be prosecuted if they were found all to have consented, connived or been negligent in relation to the offence by the provider, although this would be unlikely to occur given the high threshold required for prosecution and limited range of information that the offence would apply to at the outset. A random survey of 25 NHS trusts found an average of 6 members of an executive board listed on trust websites. Thus, based on our previous estimate that up to 2 provider cases may also involve prosecution of directors and other senior individuals, there could be up 12 additional defendants, although this is highly unlikely. As a best estimate, we might assume that at most, only one or two directors or other senior individuals who would be sufficiently involved to face prosecution.

39. Thus based on the above average cost to the CPS per defendant in the Crown Court of £2560, the additional cost of prosecuting directors or other senior individuals could at a maximum cost an additional £31,000, with a best estimate of £5200 based on the assumption of there being up to one provider case a year that would also require the prosecution of (up to two) directors or other senior individuals.

Justice System

40. There will be costs on the justice system of having a new offence under which prosecutions can be brought. It is assumed the penalties of a provider being found guilty of the offence will be a remedial order, a fine and/or a publicity order, whilst convicted directors or other senior individuals

may face either a fine or a custodial sentence of up to 2 years or both. It is assumed that cases could be tried either through the Magistrates' Courts or the Crown Court. For prudence, in terms of costing, this impact assessment assumes all cases would be tried through the more costly Crown Court.

41. It is not possible to know how much court time would be required, as it will vary case by case. As this is a new offence there is no historical data on which to form an assumption. A proxy may be cases of fraud and dishonesty, although this is a wide ranging category and will cover many cases that differ to those expected under this new offence. Ministry of Justice (MOJ) data suggests the cost to HM Courts and Tribunals Service per case of a fraud and forgery type offence in the Crown Court is around £3000 (in 2011/12 prices).

42. Based on the assumption that there will be fewer than 10 provider cases a year with a range of 0-25 the costs to the justice system may be between £0 and £75,000 with best estimate of around £30,000.

43. In the case where directors or other senior individuals also face trial, it is not clear what the additional court time might be required. On the one hand, it might be the case that there would simply be a separate additional trial for each additional individual defendant, each with an average court cost as estimated above. On the other hand, individuals could be tried together (and potentially also at the same time as the corporate body) in cases where the facts are largely the same for all defendants. If this is the case, the additional complexity of the case would mean that the resultant court cost is higher than the average cost estimated above, but unlikely to be equivalent to the cost of holding a separate trial per individual charged.

44. As it is not possible to know at this stage the number of cases that are likely to involve prosecution of directors or other senior individuals as well as the corporate body, nor the number of individuals that would be involved in each case, it is not possible to predict what the pattern of the number of defendants per trial might be or what cost implication this might have. Based on the most prudent assumption that the additional average court cost per additional defendant remains at approximately £3,000 (i.e. equivalent to the cost of holding separate trials for the each individual facing prosecution and the provider organisation) this suggests that the additional cost of prosecuting directors or other senior individuals could be as high as £36,000, with a best estimate of only £6,000.

45. In the case of an offence committed by a corporate body, it is assumed that legal aid will not be applicable. For individuals facing prosecution in the Crown Court, it is likely that they will be eligible for some legal aid. Figures from MOJ suggest that there are a range of possible estimates of the cost of legal aid. For court cases involving offences of dishonesty, these estimates range from £29,000 for high value cases to only £2,000 for low value cases. It is not yet clear where on the scale the false or misleading information offence is likely to sit. In addition, individuals are also required to pay contributions to their legal aid dependant on their income. While it is likely that directors or other senior individuals would be likely to be required to pay contributions due to their likely income, we have been advised by MOJ that it is not possible to model the size of these contributions and thus the net cost burden of legal aid that would arise. As a result, this cost is not quantifiable at this stage.

46. In terms of a custodial sentence for any individuals convicted. MOJ suggest that the cost of an average prison place is £28,000 per year. Based on a potential custodial sentence length of up to two years, with a best estimate of 2 individuals a year potentially facing prosecution, this suggests a potential cost of £112,000 per year for the prison service (and up to £675,000 based on a maximum of 12 individuals being prosecuted a year). This is based on the assumption that all individuals facing prosecution are found to be guilty and receive the maximum possible custodial sentence. This is likely to represent a significant over-estimate however in the absence of further evidence on the actual likely patterns of sentencing that would arise; we continue to use it as the most prudent assessment of the likely costs.

47. Lastly, in terms of the other sanctions, an unlimited fine for providers and individuals could be imposed. However, as a fine is a transfer payment it is not considered as an economic cost. Remedial orders and publicity orders will need to be enforced, and breach of them could result in additional costs to the justice system.

Providers of NHS funded secondary care

Ensuring due diligence in supply or publication of information

48. It is assumed that the new offence will incentivise the Board of a provider, which is responsible for the corporate body and ultimately signs off information returns, to ensure there is an culture of openness and honesty in the supply or publication of information and there is sufficient due diligence in place. For the minority of providers that purposefully or recklessly supply false or misleading information this will require the organisation to invest time and resources to change its behaviour. It will need to ensure due diligence in its information gathering, reporting and validation systems. Any costs associated with this are necessary costs that the providers should already be incurring, when complying with legal obligations to provide information. This offence does not create any additional data or information requests. The offence will apply to existing legal obligations to supply information, and any future legal obligations, and will be limited by regulations to a small number of information requirements in the first instance.

49. As discussed above it is expected that most providers of NHS funded care will already be providing accurate and robust information and be exercising sufficient due diligence. However, despite this, the new offence may still lead to costs for these providers as they go above and beyond what is necessary for fear of prosecution. As a result they may invest time and resources unnecessarily to improve their information gathering, reporting and validation, potentially at the expense of other informational returns that are not initially covered by the offence. This is a risk and is discussed further below.

50. It is not possible to know how provider behaviour will change in response to the new offence, nor how much additional resource providers will commit to submitting information returns and due diligence. In the first instance, we propose that the scope of the offence is limited by regulation to only include the mandatory Commissioning Data Set returns as required by the Health and Social Care Information Centre. This consists of the patient level activity data submitted by trusts that are used to form the National Statistics of hospital level activity and are used to construct mortality indicators. It is not known how much time providers spend collecting and quality assuring this information at present, however, for illustrative purposes, Review of Central Returns data suggests the current burden on providers of submitting mandatory central returns is around £32m[4] per annum. If the new offence leads providers, on aggregate, spending 5% more time on existing central returns then the cost could be around £1.6m per annum.

Cost of investigation and mounting a defence

51. The mechanism for identifying a provider that has committed this offence is likely to be through individual action highlighting an issue or issues being picked up in existing data validation processes already used in the system. Potentially there could be increased monitoring or checks by the responsible organisation. Any impact on providers is expected to be minimal. Therefore identification of potential non-compliance is not expected to be a significant additional burden to providers. However, any potential non compliance identified may require significant investigation before a decision to prosecute is reached. These costs would mainly fall on the investigating organisation (discussed above). However, some providers may face costs associated with initial investigation such as staff time and providing proof of due diligence. This should be limited as the policy objective is to target only those providers that are suspected of purposefully (as opposed to accidentally) providing false or misleading information. It is not possible to know what this would involve and in most cases it expected to be dealt with through existing validation processes.

52. Where there is sufficient evidence, and it is in the public interest, some providers will be charged and taken to court. As a result they will need to mount a legal defence. Defence against the proposed offence is likely to be outside of the NHS Litigation Authority process as the cases will likely relate to deliberate or reckless acts by the corporate body. It is not possible to know what the defence costs under the new offence will be. As a proxy it is assumed that the defence will be at least as costly as the prosecution. From above the average costs to the CPS per defendant in the Crown Court are £2560 (2011/12 prices), this cost is used as the assumption for provider legal costs.

[4] Uses ROCR estimates of staff time costs and DH estimates of employer national insurance costs and overheads. All mandatory or statutory central returns to HSCIC are included. This will include some non-secondary care returns and will exclude information returned directly to other bodies. ROCR data source : http://www.ic.nhs.uk/rocr data from February 2013.

53. Based on the assumption that there will be fewer than 10 cases a year with a range of 0-25 the total costs to all providers may be between £0 and £64,000 with best estimate of around £26,000 per annum.

54. Similarly, any directors or other senior individuals charged with consenting or conniving in (or being negligent in relation to) an offence by the provider would also face similar defence costs. It is not possible to know what these defence costs might be, and as before we use the average CPS costs per defendant as a proxy. Based on the assumption that at a maximum there might be up to 12 individuals facing prosecution a year, this maximum possible defence costs might be £31,000. Our best estimate is that there might be around 2 individuals facing prosecution a year, giving a total defence cost of £5,200.

55. In addition to the legal costs above, a provider defending prosecution is likely to face some costs of distraction from its core business. Directors or other senior individuals will be involved in the defence and time will be taken from their day to day responsibilities (especially if they also face prosecution as individuals). Other staff are likely to be aware of the legal case and it could impact morale and productivity. It is not possible to quantify this potential impact.

Costs of penalties

56. Where a provider is found guilty of the offence the penalty will be a fine, a remedial order and/or a publicity order. As a fine is a transfer payment it is not considered as an economic cost.

57. A remedial order sets out steps that must be taken by the provider to remedy the breach that led to the conviction. Any changes required by the provider may have resource implications; these will vary case by case and it is not possible to quantity the impact. However, these will be actions it should already be taking to provide accurate information in compliance with existing (and any future) information requests.

58. A publicity order could require the convicted organisation to publicise that is has been convicted, specifying particulars of the offence, the amount of any fine imposed and the terms of any remedial order made. There may be some administrative costs but these are expected to be negligible. The main cost of this penalty will be the negative publicity which may have an impact on future business and operations. It is not possible to estimate the extent of this potential impact.

59. Breach of either a remedial order or a publicity order would result in a further offence and thus further defence costs and a further fine.

60. In addition to a possible fine, individuals may face the personal cost of a custodial sentence. However, it is not possible to quantify what this might be.

Costs - summary

61. The costs above are summarised in the table below:

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	
Description of Costs	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**Total**
Montioring and investigation costs	UNQUANTIFIED										
Prosecution costs: CPS	£31,200	£31,200	£31,200	£31,200	£31,200	£31,200	£31,200	£31,200	£31,200	£31,200	£312,000
Court time: HMCTS	£36,000	£36,000	£36,000	£36,000	£36,000	£36,000	£36,000	£36,000	£36,000	£36,000	£360,000
Defence costs: Providers	£31,200	£31,200	£31,200	£31,200	£31,200	£31,200	£31,200	£31,200	£31,200	£31,200	£312,000
Custodial sentences	£56,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£1,064,000
Distraction costs: Providers	UNQUANTIFIED										
Ensuring information is not false or misleading: Providers	UNQUANTIFIED										
Penalties: Providers	UNQUANTIFIED										
Total Cost (undiscounted)	£154,400	£210,400	£210,400	£210,400	£210,400	£210,400	£210,400	£210,400	£210,400	£210,400	£2,048,000
Discount adjustment	1.00	1.04	1.07	1.11	1.15	1.19	1.23	1.27	1.32	1.36	
Total Present Cost (discounted)	£154,400	£203,285	£196,411	£189,769	£183,351	£177,151	£171,161	£165,372	£159,780	£154,377	**£1,755,057**

Risks

Perverse incentives

62. Making it an offence to provide inaccurate information not only deters providers from providing inaccurate information but it may also deter them from providing information at all. This potential effect should be limited as the information requirements on providers in scope of the offence are legal requirements and not discretionary. However, there may be a “bare minimum” interpretation of these legal requirements.

63. In addition, where providers do provide information, because they risk criminal sanctions if it is inaccurate and they have not exercised due diligence, they may take much more time in providing it (this is considered under costs above – Para 50). They may also provide numerous caveats that make it difficult to understand and interpret the information and data. This risk could be mitigated through provision of advice on the interpretation of false or misleading information and due diligence; this is being considered.

64. In addition, as we plan to further limit the types of information the offence is applicable to to the mandatory commissioning data sets, there is a risk that providers will choose to focus more of their attention of this data at the expense of other data requirements.

65. Therefore, although the quality of information should increase, the quantity and clarity of it may reduce, or there may be offsetting changes to other data provided by providers, and this would have a negative impact on overall transparency in the sector. As such, the benefits below may not be realised as expected.

Benefits

66. The proposed policy will allow legal action where a provider of NHS funded secondary care has provided false or misleading information and does not have sufficient due diligence in place. A provider risks a fine, a remedial order and/or a publicity order if they commit this offence. These penalties are expected to deter providers from providing false or misleading data and information. It is assumed that this will incentivise the board of directors of a provider, which is responsible for the corporate body and ultimately signs off information returns, to ensure there is an culture of openness and honesty in the supply or publication of information and there is sufficient due diligence in place. As a result of this policy those providers that may have otherwise provided false or misleading information will be less likely to do so. Consequently, the information available to the public, service users, commissioners and regulators should be of a higher quality, and thus makes health care provision more transparent.

67. In addition, the new offence will also allow providers of NHS care to be held to account if they have misled the public and the system.

68. It is not possible to quantify the deterrent effect and its beneficial impacts nor the benefits of increased accountability. The qualitative basis of them is set out below.

Service users and public

69. There is currently imperfect information in the health care market with providers having access to more information on their service quality than their service users, commissioner and regulators. The public, commissioners and regulators rely on providers of NHS care to provide/share this information and ensure its accuracy. Data and information forms a vital basis of commissioning decisions, regulatory assessments of quality and safety, and providers own monitoring and controls. False or misleading can enable poor and dangerous care to manifest and prevent regulatory or other corrective interventions to address the poor care. It can also prevent lessons being learnt and disseminated across the system.

70. For example, the Francis Inquiry found that the Mid-Staffordshire NHS Foundation Trust made inaccurate statements about their mortality rates[5]. Inaccurate statements about mortality rates delayed any investigation and thus identification of service issues. As a result corrective action was delayed and poor quality care was allowed to continue unchecked. It is estimated that hundreds of people received appalling care and/or may have died prematurely or unnecessarily at Mid Staffordshire hospital. For illustrative purposes if the loss of two years of full health could have been avoided[6] for 400[7] people the social value of this benefit would be £48m[8]. If only 100 people

[5] 2013, Francis R, Mid-Staffordshire Foundation Trust Public Inquiry, Chapter 22, Para 22.4-22.23

[6] Hogan H, Healey F, Neale G et al,(2012) "Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study", BMJ Qual Saf

[7] Lower bound estimate of potential unexpected deaths at Mid Staffordshire NHS Foundation Trust based on Healthcare Commission Report 2009

gained between 3 and 4 months of full health the social value of this benefit would still be £1.8m[9] and thus outweigh the total discounted costs of the proposal.

71. There were a number of factors involved but supply or publication of inaccurate information by the Trust was a key component in enabling this to occur.

72. Increasing transparency, by improving the accuracy of information providers use and share could improve the quality of care for service users through:

- Better provider internal monitoring and control;
- Patient choice;
- Better commissioning; and
- Better regulation:

Better provider internal monitoring and control

73. Provider boards and senior management will have access to, and consider, the information shared with other parties. The more accurate this information is, and the better the systems of gathering and reporting are, the better the understanding the organisation has of its own performance and any issues. This should enable early identification of issues and responsive corrective action by the provider. As a result, quality of care may improve and access may be protected.

Patient choice

74. More accurate information improves the ability of service users and the public to understand the quality of health services. This enables them make better informed choices about which providers to use and where to receive care. This empowers patients and incentivises providers to compete on quality. As a result, quality of care may improve.

Better commissioning

75. More accurate information improves the ability of commissioners to understand the quality of the services they are purchasing on behalf of their patient population. This enables them to make better decisions about which providers to contract for care. Improved information also improves their ability to hold providers to account and vary their contracts accordingly, which incentivises providers to provide quality services. As a result, quality of care may improve and access protected.

Better regulation

76. More accurate information allows earlier identification of potential issues with quality of care. This enables the regulators to trigger correction action sooner. This prevents problems persisting. As a result, quality of care may improve and access may be protected.

Public confidence

77. As well as improving quality of care and safeguarding access for service users, general public confidence in the health care system and the use of tax payer funds should be increased through the greater transparency brought about by more accurate information and increase accountability of providers of NHS funded care.

Commissioners and regulators

78. Where commissioners and regulators have access to more reliable and accurate information they may need to invest fewer resources in investigating providers. This may free up resources which can enable more to be spent on improving poor care rather than identifying it, and/or efficiency savings.

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[8] Based on a societal willingness to pay £60,000 per Quality Adjusted Life Year (QALY) and a potential loss of 2 QALYs per person avoided. In order not to undervalue the life of different groups, where policies increase life expectancy, each year corresponds to a full QALY, irrespective of the quality of health, age or gender of the patient.

[9] Based on a societal willingness to pay £60,000 per Quality Adjusted Life Year (QALY) and a potential loss of 0.3 QALYs per person avoided.

Value for Money

79. The below table shows the profile of the net present value of identified impacts over a 10 year period. All figures are based on assumptions and should be treated as such, however this represents our best understanding of the likely impacts:

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	
Description of Costs	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**Total**
Montioring and investigation costs	UNQUANTIFIED										
Prosecution costs: CPS	£31,200	£31,200	£31,200	£31,200	£31,200	£31,200	£31,200	£31,200	£31,200	£31,200	£312,000
Court time: HMCTS	£36,000	£36,000	£36,000	£36,000	£36,000	£36,000	£36,000	£36,000	£36,000	£36,000	£360,000
Defence costs: Providers	£31,200	£31,200	£31,200	£31,200	£31,200	£31,200	£31,200	£31,200	£31,200	£31,200	£312,000
Custodial sentences	£56,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£112,000	£1,064,000
Distraction costs: Providers	UNQUANTIFIED										
Ensuring information is not false or misleading: Providers	UNQUANTIFIED										
Penalties: Providers	UNQUANTIFIED										
Total Cost (undiscounted)	£154,400	£210,400	£210,400	£210,400	£210,400	£210,400	£210,400	£210,400	£210,400	£210,400	£2,048,000
Discount adjustment	1.00	1.04	1.07	1.11	1.15	1.19	1.23	1.27	1.32	1.36	
Total Present Cost (discounted)	£154,400	£203,285	£196,411	£189,769	£183,351	£177,151	£171,161	£165,372	£159,780	£154,377	**£1,755,057**
Description of benefits											
Improved quality of information and increased transparency	UNQUANTIFIED										
Better provider internal monitoring and control	UNQUANTIFIED										
Patient choice	UNQUANTIFIED										
Better commissioning	UNQUANTIFIED										
Better regulation	UNQUANTIFIED										
Public confidence	UNQUANTIFIED										
Total Benefits	UNQUANTIFIED										
Net Present Value	-£154,400	-£203,285	-£196,411	-£189,769	-£183,351	-£177,151	-£171,161	-£165,372	-£159,780	-£154,377	**-£1,755,057**

80. The costs are based on proxies from other investigations and prosecutions. In addition, it is not known how many providers, directors or other senior individuals would be investigated and prosecuted under the proposed offence. As such the quantified costs are estimates only. Given this they are sensitivity tested below under scenarios:

- If 5 % of providers (25) were prosecuted each year, the legal cost estimate would be around £220k pa and the NPV over 10 years would be -£2.8m.
- If all cases also involved the prosecution of a single director or other senior individual, the NPV over 10 years would be -£6m. This is mainly due to the costs associated with custodial sentences.
- If the legal costs were double the above estimates, the legal cost estimated would be around £200k pa and the NPV over 10 years would be -£2.6m
- If 5% of providers were prosecuted AND the legal costs were double the above estimate the legal cost estimate would be around £440k pa and the NPV over 10 years would be -£4.7m
- If the average length of custodial sentences served on individuals was only 6 months, the additional costs on the prison service would be £28,000 and the NPV over 10 years would be -£1.1m

81. The net present value is negative as it only includes the quantifiable identified costs. There will be additional costs which have not been possible to quantify at this stage. In addition, it has not been possible to quantify the benefits of this policy although it is known from the case study of Mid Staffordshire NHS Foundation Trust that supply or publication of misleading information did contribute to poor quality care and delayed corrective action. Therefore, as this policy deters behaviour that may give rise to a similar situation it is expected that the quality of care will improve compared to the counterfactual, and thus the benefits will be realised at least to some extent. It is impossible to know if another large ongoing failure in care would occur if this policy was not implemented. However, it is expected is that this policy will make it less likely. The social value of avoiding events such as those that occurred at Mid Staffordshire NHS Foundation Trust, even if only considering the avoided health loss, is significant.

82. Overall, the benefits of the policy to outweigh the costs if a total QALY gain of 30 can be achieved (assuming a societal valuation of £60,000 per QALY gained). This is the equivalent of a gain of 0.3 QALYs for 100 people, or a gain of 0.03 QALYs for 1,000 individuals. Due to the modest nature of the required health benefits, we are confident that the benefits of the policy are likely to outweigh the costs, even though further quantification is not possible.

One-In-Two-Out

83. It has been agreed with the Department for Business, Innovation and Skills (BIS) and the Reducing Regulation Committee (RRC) that this policy is out of scope of the One-in Two-out policy on new regulation.

84. The new offence will only apply to providers of health and social care (and directors or other senior individuals who consent or connive in, or are negligent in relation to, an offence by the provider), and will be limited in application by regulations to providers of NHS funded secondary care and certain information that they supply. This offence does not create any additional data or information requests. The offence will apply to existing legal obligations to supply information, and any future legal obligations.

85. In relation to provider organisations, the new offence will be a strict liability offence with a due diligence defence. The offence will not bite on those providers that have made a genuine mistake or administrative error in providing false or misleading information, provided they can demonstrate that they have exercised due diligence ie the provider had adequate procedures in place designed to prevent false or misleading information from being provided. Providers should already have due diligence procedures and arrangements in place, so the offence does not extend the regulatory scheme. Moreover, the offence is addressing criminal behaviour and should not be considered as regulatory. Those providers that have been reckless or wilful in providing false or misleading information will be a subset of those that fall within scope of the offence. BIS has confirmed "that if the duty to provide accurate information is breached only if a provider knowingly provides inaccurate or misleading information, it should not be regulatory". Further, "where a firm knowingly acts in a way that breaches a law or seeks to deceive, that measures to strengthen that law should not be classed as regulatory".

Section E: Equality Impact Assessment and summary of specific impact tests

Equality Impact Assessment

86. This policy proposal impacts on providers of NHS funded secondary care, including directors and other senior individuals within these organisations who may have responsibility for information provision. The costs will not impact service users or any group of individuals. The benefits of improved quality of care through better information exchange across the system will be realised by users of NHS health care. This policy will not disproportionately affect any one demographic or social group. In general, the NHS patient population tends to be people from older age groups, lower income distribution and those with disabilities or long-term conditions.

Competition

87. In any affected market, would the proposal:

- Directly limit the number or range of suppliers?

88. No. The proposals do not involve the award of exclusive rights to supply services, procurement will not be from a single supplier or restricted group of suppliers.

- Indirectly limit the number or range of suppliers?

89. No, this regulation is not a significant barrier of exit or entry into the market.

- Limit the ability of suppliers to compete?

90. This offence will apply to providers of NHS funded secondary care. All providers that hold NHS contracts face the same requirement and risk of prosecution. This offence does not apply to independent health care services that do not provide NHS care.

91. This offence does not limit the scope for innovation for the introduction of new products or supply existing products in new ways. It does not limit the sales channels a supplier can use, or the geographic area in which a supplier can operate. It does not limit the suppliers' freedoms to organise their own production processes or their choice of organisational form.

92. It does not substantially restrict the ability of suppliers to advertise their products; however, NHS providers will have provide accurate information and this may impact there reputation and advertising of services.

- Reduce suppliers' incentives to compete vigorously?

93. The proposal does not exempt the suppliers from general competition law. It does require NHS providers to provide accurate information on services to interested parties which may include information in the public domain. This should increase competition.

Small firms

- How does the proposal affect small businesses, their customers or competitors?

94. The offence would apply to providers of NHS funded secondary care of all sizes and the impacts are as described above. Most providers will not be small firms. Further, it has been agreed with BIS that this policy is not regulatory and thus not in scope of One-in Two-out.

Legal Aid/ Justice Impact

95. The following have been considered in the main impact assessment above and in the Ministry of Justice impact test provided alongside this document:

- Will the proposals create new civil sanctions, fixed penalties or civil orders with criminal sanctions or creating or amending criminal offences? **Yes**
- Any impact on HM Courts services or on Tribunals services through the creation of or an increase in application cases? **Yes**
- Create a new right of appeal or route top judicial review? Enforcement mechanisms for civil debts, civil sanctions or criminal penalties? **Yes**
- Amendment of Court and/or tribunal rules? **No**
- Amendment of sentencing or penalty guidelines? **No**
- Any impact (increase or reduction on costs) on Legal Aid fund? (criminal, civil and family, asylum) **Yes**
- Any increase in the number of offenders being committed to custody (including on remand) or probation? **Yes**
- Any increase in the length of custodial sentences? Will proposals create a new custodial sentence? **Yes**
- Any impact of the proposals on probation services? **No**

Sustainable Development

96. The proposals are not expected to have a wider impact on sustainable development. There will be no impact on climate change, waste management, air quality, landscape appearance, habitat, wildlife, levels of noise exposure or water pollution, abstraction or exposure to flood.

Health Impact

- Do the proposals have a significant effect on human health by virtue of their affects on certain determinants of health, or a significant demand on health service? (primary care, community services, hospital care, need for medicines, accident or emergency services, social services, health protection and preparedness response)

97. The potential impacts on health have been considered above in the cost benefit analysis of this impact assessment, see Section D above.

98. There are no expected health risks in association with, diet, lifestyle, tobacco and alcohol consumption, psycho-social environment, housing conditions, accidents and safety, pollution, exposure to chemicals, infection, geophysical and economic factors, as a result of the proposals

Rural Proofing

- Rural proofing is a commitment by Government to ensure domestic policies take account of rural circumstances and needs. It is a mandatory part of the policy process, which means as

policies are developed, policy makers should: consider whether their policy is likely to have a different impact in rural areas because of particular circumstances or needs, make proper assessment of those impacts, if they're likely to be significant, adjust the policy where appropriate, with solutions to meet rural needs and circumstances.

99. The proposals will not lead to potentially different impacts for rural areas or people.

Wider impacts

100. The main purpose of the proposed offence is to deter providers of NHS funded care from providing inaccurate information to protect self rather than public interest.

Economic impacts

101. The costs and benefits of the proposals on businesses have been considered in the main cost benefit analysis of this impact assessments, see Section D above.

Environmental impacts and sustainable development

102. The proposals have not identified any wider effects on environmental issues including on carbon and greenhouse gas emissions.

Social impacts

103. No impact has been identified in relation to rural issues or the justice system.

Section F: Summary and conclusion

104. Based on the above impact assessment the preferred option is Option 1: False or Misleading Information Criminal Sanction: Introduce a criminal offence for health and social care providers that supply or publish false or misleading information (and for directors and other senior individuals who consent or connive in, or are negligent in relation to, an offence by the provider), targeted through subsequent regulations on certain types of information supplied by providers of NHS secondary care, such as the data required to compile mortality rates. It is not known how many investigations and prosecutions there would be under this new offence, but it is expected to be very low.

105. There is also uncertainty about the resources required to bring prosecutions in relation to this offence, however cost assumptions have been developed in discussion with MOJ. Based on this it is expected that the costs to the HMCTS, CPS, and providers are between £0 and £975,000 with a best estimate of around £210,000 per annum (in 2011/12 prices). The large range in potential costs is mainly associated with the cost of providing custodial places for up to 2 years for each individual. In reality it is unlikely that all individuals facing prosecution would receive the maximum possible custodial sentence and so in reality costs are likely to be lower than this maximum estimate even if the assumptions on the number of cases remain high. There will be additional costs to providers (from changing their behaviour) and to the organisation(s) that will assist CPS with investigating cases. Although there are risks that this offence creates perverse incentives it is expected that the identified benefits or improved commissioning, regulation and quality of care will be realised. Although unquantified these benefits are expected to at least outweigh the identified costs.